AHCCCS is Arizona's Medical Assistance Program (Medicaid)

AHCCCS

Application for AHCCCS Health Insurance and Medicare Cost Sharing Programs

Keep Pages A, B, C and D for your Records

If you are over age 65, blind or disabled, or if you are eligible for Medicare, use this application to apply for AHCCCS Health Insurance and/or Medicare Cost Sharing programs.

How can I qualify for AHCCCS Health Insurance?

- Your gross monthly income can be no more than $798 for an individual or $1,070 for a couple (after a $20 standard deduction and other allowed deductions if you have earned income and/or dependent children).
- You must be a resident of the state of Arizona and a United States citizen or a non-citizen who meets Medicaid requirements.
- You must apply for pension, disability or retirement benefits if potentially available to you.
- If you are under age 65 and not receiving Social Security Disability income, a disability determination will be part of your application process.

What medical services are covered by AHCCCS Health Insurance?

Prescription Medication	Medical Supplies	Immunizations (shots)
Doctor's Office Visits	Prosthetic Devices	Chemotherapy
Laboratory and X-ray Services	Medically Necessary Dentures	Emergency Medical Care
Hospital Services	Medically Necessary Transportation	Emergency Dental Care
Behavioral Health Care	Medically Necessary Specialist Care	Rehabilitation Services
Dialysis	Medically Necessary Podiatry	90 days of nursing care services

How Can I Qualify for Medicare Cost Sharing Programs?

If you are receiving or eligible for Medicare Part A and you are receiving or eligible for Medicare Part B, use this application to apply for help with your Medicare premium(s), copayments and deductibles.

There are three Medicare Cost Sharing programs. Each one has a different income limit and different benefits.

Medicare Cost Sharing Program ➔	**Qualified Medicare** Beneficiary **(QMB)**	**Specified Low-Income Beneficiary (SLMB)**	**Qualified Individual – 1 (QI-1)**
General Eligibility Requirements:	• You must be a resident of the state of Arizona. • You must be a United States citizen or a non-citizen who meets Medicaid requirements. • You must apply for pension, disability or retirement benefits if potentially available to you.		
Monthly Income Limits (after allowed deductions):	$0 - $798 (Individual) $0 - $1,070 (Couple)	$798.01 - $957 (Individual) $1,070.01 - $1,283 (Couple)	$957.01-$1,077 (Individual) $1,283.01-$1,444 (Couple)
Specific Requirements:	Receiving or eligible for Medicare Part A	Receiving Medicare Part A	Receiving Medicare Part A
What is the Benefit?:	• Pays your Medicare Part B Premium • Pays your Medicare Part A Premium (if not free) • Pays your Medicare coinsurance • Pays your Medicare Deductibles* * If you are enrolled with a Medicare HMO, your co-pays will also be paid. If you elect additional coverage from a Medicare HMO, you will be responsible for any additional premiums and costs.	• Pays your Medicare Part B Premium	• Pays your Medicare Part B Premium

If you are a Qualified Disabled Working Individual (QDWI) who is under age 65 and who lost Title II Social Security Disability benefits because of earnings, use this application to apply for payment of your Medicare Part A premium.

What does AHCCCS Health Insurance cost you?

Co-payments

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in. Co-payments for services are:

- Generic Prescriptions $0 to $4
- Non-emergency use of the Emergency Room $0 to $30
- Brand Name Prescription (when Generic is available) $0 to $10
- Physician visits $0 to $5

How does AHCCCS Health Insurance work?

If you are approved for AHCCCS Health Insurance, you will receive your health care from an AHCCCS Health Plan unless:

- You are Native American and you choose Indian Health Services (IHS) as your health plan
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Cost Sharing programs, AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles, or
- AHCCCS can only pay for your emergency services because of your status with the Bureau of Citizenship and Immigration Services. If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How Does a Health Plan Work?

- The health plan works with the health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services.
- The health plan will send you a member handbook once you are enrolled.
- You can call the health plan if you have any questions about your benefits or services or if you need an accommodation because of a disability or interpreter services. The phone number for your health plan's member or customer services can be found on your AHCCCS ID Card and in your Member Handbook.

Your Primary Doctor and Specialists

- You must choose your primary doctor or one will be assigned to you.
- Once enrolled, you will get a list of primary doctors in your area from the health plan.
- Your primary doctor will:
- Take care of your health care.
- Be the first person you go to for non-emergency medical care.
- Be responsible for authorizing your non-emergency medical services.
- Send you to a specialist when needed.
- You have the right to change your primary doctor at any time by calling your Health Plan's member or customer services.

How Can I Get Behavioral Health Services?

- You can go through your primary doctor, or
  Call the behavioral health telephone number on your AHCCCS ID Card.

What if I Have Medicare or Other Health Insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS health plan, your doctor must call the AHCCCS health plan to coordinate care or you may be responsible for any Medicare or other health insurance co-payments or deductibles.
- If you are in an HMO, you should pick a primary doctor who works with both your HMO and your AHCCCS health plan.
- If you have your prescriptions filled at a pharmacy that works with your AHCCCS health plan, you may not have to make Medicare or other health insurance co-payments and there is no annual limit on prescriptions. Call your AHCCCS health plan to find out what your cost will be.

Your AHCCCS ID Card

- Your AHCCCS ID Card has your unique AHCCCS ID number.
- Show the card when you get medical care (you may need to show a picture ID as well)
- Doctors, hospitals and pharmacists use your AHCCCS ID Card to obtain faster verification of your eligibility
- Keep your AHCCCS ID Card with you at all times
- Keep your AHCCCS ID Card in a safe place
- Do not let anyone else use your AHCCCS ID Card or you may be prosecuted.

Can I apply for both AHCCCS Health Insurance and Medicare Cost Sharing programs?

Yes. If eligible, you can get AHCCCS Health Insurance and Qualified Medicare Beneficiary (QMB) benefits at the same time.

Who Can Complete an Application?

This application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your family members. The terms "applicant" and "you" on this form refer to the person applying for AHCCCS Health Insurance and/or Medicare Cost Sharing benefits. You and your spouse can use the same application form to apply. If you have a conservator or guardian, your conservator or guardian must complete this form for you.

Instructions to the Applicants

Check YES or NO on the application form when asked if you are applying for AHCCCS Medical Services or for help to pay Medicare costs. You can check YES to either question or to both.

- Answer all questions on pages 1 through 3.
- If you need more room, attach additional sheets of paper to provide all requested details.
- Read page C for an explanation of your rights and responsibilities and providing a social security number.
- Sign the application.
- Attach all requested verification when you send your application.

Keep pages A, B, C, and D for your records and mail pages 1 through 3 to

AHCCCS SSI/MAO
1205 E. Washington St. Mail Drop 400
Phoenix AZ 85034

- If you are applying for AHCCCS Health Insurance, read page D and choose an AHCCCS health plan.
- If you have any questions regarding these programs, or need help filling out the application, please call AHCCCS SSI/MAO. From area code 480, 602 or 623, dial (602) 417-5010 and choose option 3. If calling from area codes 520, 760 or 928, dial toll free 1-800-528-0142.

After we receive your application, we will either contact you for additional information or, if your application is complete, make a decision about whether you qualify. We will send you a notice explaining the decision.

RIGHTS AND RESPONSIBILITIES OF APPLICANTS/RECIPIENTS

You have the **RIGHT** to:

1. Be treated fairly and equally regardless of race, religion, national origin, sex, age, disability, or political beliefs.

2. Review policy manuals or the rules if you question the basis on which your eligibility is approved or denied.

3. Have all information you give regarding your eligibility kept confidential, according to state and federal law.

4. A hearing, if you have provided all information and verification requested and you have not been told in writing within 45 days whether or not you qualify. Your hearing will be conducted by an Administrative Law Judge who will listen to your case. If you wish to ask for a hearing, your request must be in writing and mailed or Faxed to: AHCCCS Administration, Office of Legal Assistance, 701 East Jefferson, Mail Drop 6200, Phoenix, Arizona, 85034, FAX: 602-253-9115.

You have the **RESPONSIBILITY** to:

1. Provide AHCCCS with the needed information to correctly determine your eligibility and authorize AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility.

2. Take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to Social Security benefits, Railroad Retirement, Veteran's benefits and unemployment compensation.

If you are eligible you **MUST**:

1. Notify the AHCCCS/ALTCS office as soon as possible but no later than within 10 days by phone, letter or in person, whenever there are any changes in your income, address, marital status, Medicare coverage, household composition, or other circumstances which could affect your eligibility.

2. Cooperate with Arizona or Federal personnel in the completion of a quality control review of your eligibility.

PROVIDING SOCIAL SECURITY NUMBERS

You must provide or apply for a Social Security number (SSN) for every applicant or recipient of AHCCCS Medical Services. This is required under the Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369. Providing a Social Security number for someone who is not applying is optional. We will not use your SSN as your AHCCCS identification number. Your SSN will be used to check the identity of those receiving assistance, to prevent double payments, to determine benefits available under other programs and to make mass annual changes more easily. Your SSN will be used in computer matching available through the State Income and Eligibility Verification System (IEVS) to obtain wage, income and other information from: (a) the IRS, (b) the Social Security Administration, (c) Arizona Department of Economic Security, and (d) other states administering TANF, Medicaid, Unemployment Insurance, Food Stamps, Programs under Title I, X, XIV, XVI of the SSA and other state wage information collection agencies. AHCCCS will use the information available from this computer matching to verify income and whether you have Medicare. When the information you give is questionable, AHCCCS will verify the information by contacting other sources.

ASSIGNMENT OF RIGHTS TO OTHER BENEFITS FOR MEDICAL CARE

(Applicable only to AHCCCS Health Insurance and the Qualified Medicare Beneficiary Program)

I understand that if I am or members of my family are approved for AHCCCS benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for our health care costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that AHCCCS cannot collect more than the costs paid by AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

How to choose a health plan

YOU NEED TO CHOOSE A HEALTH PLAN THAT SERVES YOUR COUNTY.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. Native Americans may choose IHS or an AHCCCS Health Plan.
- Before choosing, check with your doctor, pharmacy or hospital, to see if they contract with (work with) the plan that you want. If you want more information about the doctors, specialists or hospitals that contract with a health plan that serves your county, call the number listed below for the health plan or ask your Eligibility Specialist for the health plan's list of health care providers.
- If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

APACHE COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice 1-800-322-8670
Indian Health Service 928-729-7001
If your zip code is 85943, you must choose from among the health plans listed under Navajo County.

COCHISE COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 520-295-2495

COCONINO COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice 1-800-322-8670
Indian Health Service 928-283-2501
If your zip code is 86336 or 86340, you must choose from among the health plans listed under Yavapai County.

GILA COUNTY
PHP/Community Connection 1-800-747-7997
Health Choice 1-800-322-8670
Indian Health Service 928-475-2371

GRAHAM COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 928-475-2686
If your zip code is 85643, you must choose from among the health plans listed under Cochise County.

GREENLEE COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 928-475-2371

LA PAZ COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 928-669-2137

MARICOPA COUNTY
PHP/Community Connection 1-800-747-7997
Care 1st 1-866-560-4042
Health Choice Arizona 1-800-322-8670
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
Indian Health Service 602-263-1200

MOHAVE COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice 1-800-322-8670
Indian Health Service 928-769-2204
If your zip code is 86434, you must choose from among the health plans listed under Yavapai County.

NAVAJO COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice 1-800-322-8670
Indian Health Service 928-338-4911

PIMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Mercy Care Plan 1-800-624-3879
Pima Health System 1-800-423-3801
University (only for current enrollees)…… 1-888-708-2930
Indian Health Service 520-295-2495
If your zip code is 85645, you must choose from among the health plans listed under Santa Cruz County.

PINAL COUNTY
PHP/Community Connection 1-800-747-7997
Health Choice 1-800-322-8670
Indian Health Service 520-562-3321
If your zip code is 85342 or 85220, you must choose from among the health plans listed under Maricopa County. If your zip code is 85292 you must choose from among the health plans listed under Gila County.

SANTA CRUZ COUNTY
Arizona Physicians, IPA 1-800-348-4058
Pima Health 1-800-423-3801
Indian Health Service 520-295-2495

YAVAPAI COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 602-263-1200
If your zip code is 85342, 85358 or 85390, you must choose from among the health plans listed under Maricopa County. If your zip code is 86351 you must choose from among the health plans listed under Coconino County.

YUMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Indian Health Service 760-572-0217

IMPORTANT

When you have chosen a health plan you can either:

- Write your choice on Page 3, OR
- Call AHCCCS to pre-enroll. From area codes 480, 602 or 623 call (602) 417-7100 or from area codes 520 or 928 call 1-800-334-5283. When you call to pre-enroll, you will need to give the following information:
  - Name
  - Sex (male or female)
  - Date of birth, and
  - Social Security Number of all the individuals for whom you applied.

If you have any questions about enrolling with an AHCCCS health plan, need an interpreter, or if you are visually or hearing impaired and need special accommodations to choose a health plan or to understand the information, from area codes 480, 602 or 623 call (602) 417-7100 or TDD (602) 417-4191 or from area codes 520 or 928 call toll free at 1-800-334-5283 or TDD 1-800-826-5140.

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AHCCCS APPLICATION FORM

AGENCY USE ONLY	Date Filed

Are you applying for AHCCCS Medical Services? ❑ YES ❑ NO

Are you applying for help to pay Medicare costs? ❑ YES ❑ NO

APPLICANT INFORMATION			ACN:
First Name / MI / Last Name			Social Security Number
Date of Birth / Age / Are you: ❑ Male or ❑ Female			Medicare Claim Number
Place of Birth ❑ U.S.A ❑ Other Country _____			
Are you a U.S. Citizen? ❑ Yes, a U.S. citizen ❑ No, not a U.S. citizen			If no, what number is on your immigration card? ID# **A**
Home Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Home Phone Number	Work Phone Number	Message Number	

What language do you speak? ❑ English ❑ Spanish ❑ Other _____

What language do you read? ❑ English ❑ Spanish ❑ Other _____

Ethnic Group - Optional (will not affect eligibility) ❑ Hispanic ❑ Non-Hispanic Latino

Race - (Select one or more) (Optional) ❑ White ❑ Asian ❑ Native American Tribe: _____

❑ Black/African American ❑ Hawaiian or other Pacific Islander ❑ Alaska Native

Check your current Marital Status: ❑ Never Married ❑ Married ❑ Divorced ❑ Common-Law ❑ Widowed	Effective Date of Current Marital Status:
If married, do you and your spouse live together? ❑ YES ❑ NO	If NO, date of separation:

If you want to allow someone else to represent you or you have a legal guardian, provide the information below.

Representative's First and Last Name	Representative's Relationship to You	Representative's Phone Number
Representative's Mailing Address Street	City, State	Zip Code

By signing below, I:

- Give permission for my representative to complete and sign my application;
- Give permission for my representative to provide any documents requested, including personal information;
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to AHCCCS;
- Give permission for AHCCCS or DES to tell my representative about my eligibility; and
- Agree to give personal information to my representative.

Signature of Applicant (not needed if you have a legal guardian or you are unable to sign because you are incapacitated):	Date:

SPOUSE INFORMATION, If living together		ACN:
Spouse's First and Last Name	Spouse's Date of Birth	Spouse's Social Security Number
Is your spouse applying for AHCCCS Medical Services? ❑ YES ❑ NO Is your spouse applying for help to pay Medicare Costs? ❑ YES ❑ NO		If applying, Spouse's Medicare Claim Number

If applying, Ethnic Group of Spouse (Optional) ❑ Hispanic ❑ Non-Hispanic Latino

If applying, Race of Spouse (Select one or more) (Optional) ❑ White ❑Asian ❑ Native American Tribe:_____

❑ Black/ African American ❑ Alaska Native ❑ Hawaiian or other Pacific Islander

If applying, is your spouse a U.S. citizen? ❑ Yes, a U.S. citizen ❑ No, not a U.S. citizen	If no, what number is on your immigration card? ID# **A**

DEPENDENT CHILDREN INFORMATION

Do you have any unmarried children living with you who are under age 18 or under age 22 and a student? ❑ YES ❑ NO
If YES, list below. If you need more space, attach a separate piece of paper with the information requested.

	Child's Full Name (Last, First)	Child's Date of Birth	Child's Social Security No. (optional)	Type of School, If Student
A.				
B.				

NON-FINANCIAL INFORMATION	Applicant	Spouse (if applying)
1. Do you live in Arizona?	❑ YES ❑ NO	❑ YES ❑ NO
2. Do you receive Medicare Part A?	❑ YES ❑ NO	❑ YES ❑ NO
3. Do you receive Medicare Part B?	❑ YES ❑ NO	❑ YES ❑ NO
4. Have you been determined blind or disabled by the Social Security Administration?	❑ YES ❑ NO	❑ YES ❑ NO
5. If you answered NO to number 4 and you are under age 65, do you have a disability that has kept or will keep you from working for at least 12 months?	❑ YES ❑ NO	❑ YES ❑ NO
6. Are you a person under age 65 who has lost Title II Social Security Disability benefits because of earnings?	❑ YES ❑ NO	❑ YES ❑ NO

FINANCIAL INFORMATION - INCOME

Do you, your spouse, or your dependent children receive or expect to receive any of the following types of income? Check YES or NO for each item.

❑ Yes ❑ No Employment Income	❑ Yes ❑ No Veteran's Benefits	❑ Yes ❑ No Rental Income
❑ Yes ❑ No Self Employment Income	❑ Yes ❑ No Annuity Income	❑ Yes ❑ No Mortgage/Contract Payments
❑ Yes ❑ No Social Security Benefits	❑ Yes ❑ No Winnings (Lottery/Gambling)	❑ Yes ❑ No Child Support/Alimony
❑ Yes ❑ No Interest on financial accounts	❑ Yes ❑ No Gifts/loans/contributions	❑ Yes ❑ No BIA/Tribal Assistance
❑ Yes ❑ No Royalties/Dividends	❑ Yes ❑ No Disability Insurance	❑ Yes ❑ No Payments from a trust
❑ Yes ❑ No Cash Assistance	❑ Yes ❑ No Unemployment Insurance	❑ Yes ❑ No Tips or Commissions
❑ Yes ❑ No Pensions	❑ Yes ❑ No Student Grants/ Scholarships/Loans	❑ Yes ❑ No Earned Income Tax Credit (EITC)
❑ Yes ❑ No Railroad Retirement	❑ Yes ❑ No Payments for Room/Board	❑ Yes ❑ No Other: _____

For each item marked YES, provide all of the information requested below. If you need more room, attach a separate piece of paper containing the requested information. SEND CURRENT VERIFICATION OF ALL INCOME LISTED (FOR EXAMPLE, CHECK STUBS, AWARD LETTERS, THE MOST RECENT INCOME TAX FORMS, IF SELF EMPLOYED). COPIES ARE ACCEPTABLE.

Name of Person Receiving the Income	Type of Income	Date received or expected to be received	Gross Amount (before deductions)	How often received?

Has there been a change in any of your income during the last three months or do you expect a change in income? θ YES θ NO If YES, complete below. If you need more room, attach a separate piece of paper with the information requested.

Date of change or expected change	Type of income affected	What is the change?

POTENTIAL BENEFITS

Are you or your spouse a veteran? ❑ YES ❑ NO | Are you the widow/widower of a veteran? ❑ YES ❑ NO

Have you, your spouse or your deceased spouse ever worked for a government agency, or employer with a disability or pension plan? ❑ YES ❑ NO

If you answered YES to any of these questions, provide the following information about the veteran or employee:

Name	Social Security Number	Date of Birth	Date of Death
Dates of employment and/or Military service		Employer's address	
Employer/Branch of Service			

MEDICAL COVERAGE

Do you or your spouse have medical insurance coverage, other than Medicare? ❑ YES ❑ NO
If YES, complete the information below and SEND A COPY OF THE INSURANCE ID CARD.

Name of Insurance Company	Who is covered by Insurance

Do you or your spouse have an injury or illness resulting from an accident (pedestrian, automobile, or other vehicle, on the job, etc.)? ❑ YES ❑ NO If YES, complete the items below:

Injury ❑ YES ❑ NO

Name	Type of Injury	Date of Injury	Name and Address of Insurance or Company Responsible for Medical Costs due to the Injury

❑ Injury Referral form (DE-124)

Date: _____

If eligible for AHCCCS Medical Services or QMB, I agree to assign to AHCCCS all rights to third party payments of medical expenses, including insurance coverage, to the extent that costs are paid by AHCCCS. _____ (initial)

HEALTH PLAN CHOICE

If you are applying for AHCCCS Medical Services, choose an AHCCCS health plan that serves your county. See page D for a list of health plans.

Name of Health Plan you Choose (from page D)

PENALTY WARNING

The information provided on this form may be verified by federal, state, and local officials. If anything is inaccurate, you may be denied benefits.

1. You must not knowingly withhold or give false information with the intent to receive or to continue receiving AHCCCS benefits to which you are not entitled.
2. You will be required to pay back to AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.

It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

RELEASE OF INFORMATION

I authorize AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility. If eligible, I agree to the release of eligibility information by AHCCCS to Blue Cross/Blue Shield or another intermediary for determining Medicare Cost Sharing payments.

STATEMENT OF TRUTH

I swear or affirm under penalty of perjury that the oral or written statements made regarding the persons in my home, my income, and any other items that pertain to my possible eligibility for AHCCCS Medical Services or Medicare Cost Sharing program benefits are true and correct to the best of my knowledge and that any photocopies I have provided are the same as the original. I have read and understand the penalty warning. I have read and understand my rights and responsibilities, and providing Social Security numbers on page C of this application. I further agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.

Signature of Applicant	Date
Signature of Spouse	Date
Signature of Witness (if applicant signed with a mark)	Date
Signature of Representative	Date

OFFICE USE

AHCCCS OFFICES

SSI MAO
1209 E. Washington, MD 400
Phoenix, AZ 85034

- Calling from area codes (602, 480 or 623) dial (602) 417-5010 and choose option 3.
- Calling from area codes (520, 760 or 928) dial toll free 1-800-528-0142.

CASA GRANDE
500 North Florence Street
Casa Grande, Arizona 85222
(520) 421-1500

CHINLE
DCI Shopping Center
US Highway 191, PO Box 1942
Chinle, Arizona, Navajo Nation, 86503
(928) 674-5439 (area codes 520, 760, or 928)
1-888-800-3804 (area codes 602, 480, or 623)

COTTONWOOD
1 North Main Street
Cottonwood, Arizona 86326
(928) 634-8101 (area codes 520, 760, or 928)

FLAGSTAFF
3480 East Route 66
Flagstaff, Arizona 86004
(928) 527-4104 (area codes 520, 760, or 928)
1-800-540-5042 (area codes 602, 480, or 623)

GLENDALE
2830 West Glendale Avenue, Suite 34
Phoenix, Arizona 85051
(602) 417-6000 (area codes 602, 480, or 623)
1-800-528-0142 (area codes 520, 760, or 928)

GLOBE/MIAMI
Cobre Valle Plaza
2250 Highway 60, Suite H
Miami, Arizona 85539-9700
(928) 425-3165 (area codes 520, 760, or 928)
1-888-425-3165 (area codes 602, 480, or 623)

KINGMAN
519 East Beale Street, Suite 150
Kingman, Arizona 86401
(928) 753-2828 (area codes 520, 760, or 928)
1-888-300-8348 (area codes 602, 480, or 623)

LAKE HAVASU CITY
285 South Lake Havasu Avenue
Lake Havasu City, Arizona 86403
(928) 453-5100 (area codes 520, 760, or 928)
1-800-654-2076 (area codes 602, 480, or 623)

MESA
460 North Mesa Drive, Suite 101
Mesa, Arizona 85201
(602) 417-6400 (area codes 602, 480, or 623)
1-800-528-0142 (area codes 520, 760, or 928)

PHOENIX SOUTH
700 East Jefferson Street
Phoenix, Arizona 85034
(602) 417-6600 (area codes 602, 480, or 623)
1-800-528-0142 (area codes 520, 760, or 928)

PRESCOTT
1570 Willow Creek Road
Prescott, Arizona 86301
(928) 778-3968 (area codes 520, 760, or 928)
1-888-778-5600 (area codes 602, 480, or 623)

SHOWLOW
580 East Old Linden Road, Suite 3
Showlow, Arizona 85901
(928) 537-1515 (area codes 520, 760, or 928)
1-877-537-1515 (area codes 602, 480, or 623)

SIERRA VISTA
484 East Wilcox Drive
Sierra Vista, Arizona 85635
(520) 459-7050 (area codes 520, 760, or 928)
1-888-782-5827 (area codes 602, 480, or 623)

TUCSON
Magdalena Building
110 South Church Avenue, Suite 5132
Tucson, Arizona 85701
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